Social and Rehabilitation Services
Integrated Service Delivery

IS-3122
01-04

Disability Consultation / Representation Referral to Kansas Legal Services

☐ Adult ☐ Child

Client's Name: _____ SRS Case Number: _____ SSN _____

Street Address: _____ City/ State : _____ Zip: _____

Telephone: _____ DOB: _____ Gender: _____ County of Residence: _____

Alternative Contact Information for Client: **Telephone:** _____ **Mailing Address:** _____

Referred by (Name/Title): _____ Agency/SRS office: _____ Telephone: _____

E-mail address: _____ @srskansas.org Date Referred to KLS _____

Medical Statement(s) Attached: Yes ____ No ____

Program Type: TAF: ☐ GA: ☐ CINC: ☐ Fam. Pres. ☐ Fam. Serv. ☐ Emerg. Shelter: ☐ Other: ☐

FOR CHILDREN ONLY:

The following information will help in determining if the child has a physical or mental problem and could receive SSI. (Please check any that apply.) Remember to consider the child's age–inability to do an activity is a problem only if he or she should be capable of it at that age. Does the child have problems:

Communicating ____ Feeding ____ Playing ____ With turning ____ Understanding Speech ____

Walking ____ With Head Control ____ Washing ____ Socializing ____ Using the bathroom ____

Going to School ____ With School Performance ____ Speaking ____ Crawling ____ Other ____

Swallowing ____ Eating ____ Dressing ____ Paying Attention ____ Explain: _____

Is the child in a special education class? Yes ____ No ____ Is the child in a special needs school? Yes ____ No ____

Has an SSI application ever been made for the child? Yes ____ No ____ If yes, when _____ Results: _____

Are parental rights severed on this child? Yes ____ No ____ Are there reports of child abuse or neglect on file? Yes ____ No ____

Authorization to Release Information:

Now on this ____ day of _____ 20 ____ , I _____

hereby consent and authorize the State Department of Social and Rehabilitation Services to release any and all records and information in their possession, control, and custody to Kansas Legal Services for the purpose of providing advice and/or representation concerning the above named client's Social Security disability claim. I release the State Department of Social and Rehabilitation Services from any liability for giving such information.

I also consent and authorize Kansas Legal Services to release any and all records and information in their possession, control, and custody concerning advisement and/or representation of the above named client's Social Security disability claim to the State Department of Social and Rehabilitation Services for purposes of program administration, monitoring, and evaluation of the Social Security Disability Advocacy Project. I release Kansas Legal Services from any liability for giving such information.

Client (Parent/Guardian) Signature: _____ Date: _____

Original and 1 copy: KLS; Copy: Client, SRS Central Office, Referring Agency, SRS office managing case